Automated Additional Developement

Procedure Flow

I. Control (8th Fl)
   A. Receive Letter Forms
      1. Burst
      2. Sort and Designate
         a. Doctor
         b. Beneficiary
         c. Rep-Payee
         d. Letter Not Written & Misprints

   B. Forward Letter Forms
      1. (a,b,c, above) Mailroom (1st fl)
      2. (d above) Central Control (19th fl)

II. Mail Room (1st Fl)
   A. Stuff & Mail Out Letter Forms
      1. Doctor (letter & return envelope)
      2. Beneficiary (letter, return envelope and Privacy Act)
      3. Rep-Payee (letter, return envelope and SSA 1660 Form)

   B. Receive Returned & Replied Letter Forms
      1. Forward to Mailroom (15th fl)

III. Mail Room (15th Fl)
   A. Receive Replied ADR Forms
      1. Open
      2. Sort by clerk number (apha code suffix)
      3. Deliver Forms
         a. 16th Central Control
         b. 19th Central Control

   B. Receive Returned Letter (invalid address)
      1. Open
      2. Forwarded to CRT Research Clerk

IV. CRT Research Clerk (15th Fl)
   A. Research CRT
      1. MEBND (Bene-Name and Address File)
         a. Address change
      2. MECC (Control File)
         a. HIB change

   B. Check Cast Tapes

   C. Pull Original Claim or Microfilm
      1. Check Address change

   D. Update CRT (address or HIB)

   E. Fill in back of letter form
      a. Any corrections to HIB
      b. Add 'AA' in ADR Field

   F. Forward Forms to Data Recording

V. Central Control (16th Fl)
   A. Receive Batches

1. Maintain current control procedures
   a. Pickup & deliver to Examiners
   b. Organize & release batches to Edit Control

2. Receive letter forms
   a. Pickup & deliver to Originating Examiner
   b. Deliver forms to Data processing

3. Pickup & deliver Set-ups to 15th simplex

4. Receive letters not written & misprints (from 19th fl)
   a. Deliver to AD (Watts) Clerk

VI. Central Control (19th Fl)
   A. Receive Batches & Suspense Forms
      1. Maintain current control procedures
         a. Organize Batches & attach Suspense Forms
         b. Count Suspense & Log to Clerks
         c. Pickup & deliver to Data Processing
            1. Suspense Forms
            2. AD Requests
            3. Letter Forms

   B. Receive Letter Forms
      1. Pickup & deliver to originating clerk

   C. Receive Print out of Unable to Write Letters
      1. Types
         a. More than 5 questions
         b. Misprint Letters

      2. Match to Claim
         a. (a & b above) forward to 16th Central Control or Edit Watts Clerk (according to originating Clerk #)

   D. Receive all entries from Data Processing
         a. Forward to Edit Research Clerk (7000 listing & Correction Register)

VII. Claims Examiners (16th & 17th)
   A. Manual (Pre ADR)
      1. Screen & Code Claim
         a. Fill in all possible information
         b. Fill in AD Request information
            1. $ (Doctor) in field missing information a XX (Alpha-numeric Question Code) in AD field

            2. # (Bene) in field missing information a XX (Alpha-numeric Question Code) in AD field

            3. $ XX or #XX in field missing information

      2. Make all necessary Set-ups (Deceased)
         a. Fill in all possible information
         b. Fill in AD Request (as above) information
         c. Set aside for pickup & delivery to 15th fl Simplex

3. Set aside batch for pickup & delivery
   a. To data processing
   b. To DDE Terminals

B. Manual Examiners (Post ADR)
   1. Receive Letter Reply
      a. Complete back of letter form
         1. Line out and add information on (as is presently done on Suspense Forms)

         2. Set aside for pickup & delivery to Data processing

      b. Request new letter on old letter form
         1. Add 'AD' to field code area with SXX or #XX in Data field

         2. Add $XX or #XX in field missing information with 'AD' in field code area.

         3. Set aside for pickup & delivery to Data processing

      c. Request same letter on old letter form
         1. Add 'AA' in field code area
         2. Set aside for pickup & delivery to Data processing

      d. Delete claim or AD Tag from Suspense
         1. Obtain original claim
         2. Forward to Supervisor*

* procedures listed under Resolution Area.

C. DDE Terminal (Exam & Entry) (Pre ADR)
   1. Screen Claim

   2. Enter all possible information

   3. Enter AD Request information (as above)
      a. Make notation on REP in pencil the info requested (Ex - $ BB,FF)

   4. Set aside Batch for pickup & delivery to 19th floor

D. DDE Terminal (Exam & Entry) (Post ADR)
   1. Receive Letter Reply
      a. Complete back of letter form (as above)
      b. Request new letter (as above)
      c. Delete claim or ADR Tag (as above)
      d. Request same letter written (as above)

   2. Set aside for pickup and delivery to Data processing

E. DDE Terminal (Entry only) (No Returned Replies)

1. Enter batch exactly as coded
   a. Manually coded batches (with AD Requests of $ or # XX)
   b. Setup batches (with AD Requests as above)
   c. Add pay or Reprocess batch (no AD requests)

2. Enter Originating Clerks number on manually coded or setup batches.

F. AD (Wats) Clerk (Letters not written by System)
   1. Receive Letters not written - (over 5 Questions)

   2. Make Request by Telephone
      a. Information received
         1. Write information on form
         2. Return to originating clerk

      b. Information not received or no answer within 2 days
         1. Cross reference alpha-numeric question code to numeric code &

         2. Indicate full name and address of Doctor in question and

         3. Indicate information in questions such as date, type of service or money amount

         4. Forward to 2nd floor word processing

         5. Receive back & mail out letter (as above in mail room procedures)

VIII. Word Processing (2nd fl)
   A. Receive AD Requests
      1. Forward to MTST Typist
      2. Type AD Question number
         a. Fill in Doctors name & address
         b. Fill in Bene's name & HIB
         c. Fill in blank spaces as indicated

   B. Return letter back to (Wats) AD Clerk

IX. Data Processing 15th
   A. Receive Manually Coded Batches
      1. Enter claims exactly as coded allowing $X or XX or #X or XX

   B. Receive Correction
      1. Suspense forms
         a. correction
         b. AD Request ($X or XX or #X or XX)
         c. Release
         d. Delete

      2. AD Request (Form 832-B)

      3. AD Reply letter form
         a. Correction

b. New letter request (AD)
c. Same letter Request (AA)
d. Delete

C. Make entry as coded
1. Enter 'R' at end of record to complete each entry on letter forms

D. Forward all claims, forms, and letters to 19th Central Control

X. Resolutions (Edit) I, II, & Prepayment Screening
A. Receive Suspense Forms & Claims
1. Screen & make necessary corrections to all fields but those already containing $ or #.

2. In error correction & field code area the suspense form show type letter & Question code and Field of information
a. $\frac{\$12}{19}$
b. #_74

3. Request AD/Pend Suspense Forms
a. Complete AD Form 832-B

4. Request AD/Release Suspense Form
a. Complete AD information on suspense form ($XX or #XX)

5. Delete Claim (Completely off Suspense file)
a. Write Delete across Suspense form.
b. Transfer out Control number on CRT or,
c. Delete Control number from CRT
d. Forward claim accordingly

6. Release claim (Release Correction tag only)
a. Write 'Release' across Suspense Form
b. Refile Claim

B. Receive Letter Reply
1. Complete back of letter form
a. Request New letter
b. Request Same letter
c. Delete claim (as above will delete entire claim from suspense file) (Anytime a claim is deleted. The original claim must be obtain and be forwarded after deletion)

C. Delete AD Tag from Suspense
1. Delete or Release Suspense Form as above
a. (as above)

2. Complete AD Request Sheet (832-B)
a. Enter every line item of AD Request
b. Add '_' (dash) in Data field

D. Receive letters not written (over 5 quest.)
1. Make Request by Telephone (as above)

2. Forward to work processing (as above)

E. Forward all Suspense forms, letter forms, and AD Request Sheets to Data Processing.

F. Receive suspended 24 disallow
   1. EE - 495 (This claim has pended AD for 45 days/unable to 24 assigned claim without Doctor code.
      a. Research Doctor/Supplier Code
      b. Obtain Dr/Supp Code
         1. Correct Form
         2. Request AD accordingly
      c. Not able to obtain Dr/Supp code
         1. Delete Suspense Form
         2. Locate Control number (TO FER)
         3. Front End Reject entire claim

G. Suspense Followup Research
   1. 45 day parameter
   2. 1 = Edit Error, 2 = AD Request
   3. Follow-up will indicate
      a. 'ADR' if ADR only
      b. 'Corr' if Edit Error Correction only
      c. 'ADR & Corr' if both (in addition to the '2' code)
   4. Any '2' on file over 45 days notify control analyst

H. Receive all Data Processing Entries
   1. Batch (handle routinely)
   2. Suspense Forms (7000 & Correction register)
   3. AD Request Forms (correction register)
   4. Letter Reply Forms (correction register)

I. Forward batches & Letter Replies to Record Retentions (Basement)

XI. Record Retentions (Basement)
   A. Receive Batches, Letter Replies & all refiles
      1. Organize & file batches
      *2. Group & file Letter Replies
         a. In corresponding batch
         b. In Group in front of claims (not necessarily to original claim)
      3. Organize & file all loose claims

* Temporary - Possibility of Microfilming all letter Replies.

Sample Example

DATE
RE:
HIB
CLAIM

_____
_____
_____
_____

DEAR _____:

IN ORDER FOR BLUE SHIELD OF FLORIDA INC. TO ACCURATELY PROCESS THE MEDICARE CLAIM FOR SERVICES PROVIDED BY _____ WHICH WE RECEIVED ON _____ WE MUST OBTAIN THE ADDITIONAL INFORMATION REQUESTED BELOW. AFTER FILLING IN THE REQUESTED INFORMATION, PLEASE RETURN THIS LETTER TO US IN THE ENCLOSED ENVELOPE WITHIN 10 DAYS.

1.

2.

3.

4.

5.

PLEASE NOTE: TO COMPLETE THE ABOVE INFORMATION IT MAY BE NECESSARY TO TAKE THIS LETTER TO YOUR PHYSICIAN AND HAVE HIM FILL IN THE INFORMATION FOR YOU. WE ARE SORRY TO HAVE BOTHERED YOU WITH THIS REQUEST FOR INFORMATION. HOWEVER, AS A MEDICARE CARRIER, WE MUST FOLLOW DETAILED FEDERAL REGULATIONS WHICH REQUIRE THAT CERTAIN INFORMATION BE ON HAND BEFORE PAYMENT WITH FEDERAL FUNDS CAN BE MADE.

WE APPRECIATE YOUR RESPONSE TO OUR QUESTIONS AND WE WILL PROCESS THE CLAIM AS QUICKLY AS POSSIBLE WHEN YOU RETURN THIS LETTER.

(OPTIONAL SECOND REQUEST)

PLEASE NOTE: THIS IS OUR SECOND REQUEST. IF YOU HAVE ALREADY RESPONDED TO OUR FIRST REQUEST, PLEASE DISREGUARD THIS LETTER.

SINCERELY,

S. CARLTON

DATE
RE:
HIB
CLAIM

_____
_____
_____
_____

DEAR_____:

IN ORDER FOR BLUE SHIELD OF FLORIDA INC. TO ACCURATELY PROCESS THE MEDICARE CLAIM FOR SERVICES PROVIDED FOR _____ WHICH WE RECEIVED ON _____ WE MUST OBTAIN THE ADDITIONAL INFORMATION REQUESTED BELOW. AFTER FILLING IN THE REQUESTED INFORMATION, PLEASE RETURN THIS LETTER TO US IN THE ENCLOSED ENVELOPE WITHIN 10 DAYS.

(UNASSIGNED) (OPTIONAL)

PLEASE NOTE: THIS IS A NON-ASSIGNED CLAIM AND MAY HAVE BEEN SUBMITTED BY YOUR PATIENT. IT DID NOT CONTAIN THE INFORMATION BEING REQUESTED ABOVE. WE ARE SORRY TO HAVE BOTHERED YOU WITH THIS REQUEST FOR INFORMATION. HOWEVER, AS A MEDICARE CARRIER, WE MUST FOLLOW DETAILED FEDERAL REGULATIONS WHICH REQUIRE THAT CERTAIN INFORMATION BE ON HAND BEFORE PAYMENT WITH FEDERAL FUNDS CAN BE MAKE.

(OPTIONAL SECOND REQUEST)

WE APPRECIATE YOUR RESPONSE TO OUR QUESTIONS AND WE WILL PROCESS THE CLAIM AS QUICKLY AS POSSIBLE WHEN YOU RETURN THIS LETTER.

PLEASE NOTE: THIS IS OUR SECOND REQUEST. IF YOU HAVE ALREADY RESPONDED TO OUR FIRST REQUEST, PLEASE DISREQUARD THIS LETTER.

SINCERELY,

S. CARLTON

ADR QUESTIONS

OPTIONAL INFORMATION

0 = NO OTHER DATA

1 = TYPE OF SERVICE

2 = DATE OF SERVICE

3 = CHARGE (DETAIL)

4 = PROVIDER OF SERVICE

CLAIM HEADER QUESTIONS

QUES	INFO	FIELD	DISA	MESSAGE TEXT
74	0	NM	24	VERIFY FULL NAME OF MEDICARE PATIENT_____ _____
75	0	NM	24	VERIFY PATIENT'S COMPLETE MEDICARE HEALTH INSURANCE CLAIM NUMBER (INCLUDING 9 DIGITS AND A LETTER SUFFIX.)_____
76	0	NM	24	ADVISE THE COMPLETE ADDRESS OF THE PATIENT_____ _____
77	4	DT	DA	ADVISE PATIENT'S FAMILY RELATIONSHIP TO PROVIDER "PROVIDER OF SERVICE."
05	0	DF	20	THE SIGNATURE OF THE PATIENT WAS OMITTED ON THE CLAIM REFERENCED ABOVE. PLEASE SIGN HERE TO COMPLETE THE REQUEST FOR PAYMENT._____
06	4	DT	DB	SIGNATURE OF PROVIDER OF SERVICE IS REQUIRED ON ALL 1490's UNLESS A STATEMENT IS ATTACHED. PLEASE SIGN HERE TO COMPLETE REQUEST FOR PAYMENT_____
07	0	DF	20	SIGNATURE AND ADDRESS OF WITNESS AND THEIR RELATIONSHIP TO THE PATIENT IS REQUIRED. PLEASE SIGN HERE TO COMPLETE THE REQUEST FOR PAYMENT_____

DETAIL QUESTIONS

QUES	INFO	FIELD	DISA	MESSAGE TEXT
08	1,2, 3	DR	DC	ADVISE THE NAME AND ADDRESS OF THE PROVIDER OF "TYPE OF SERVICE" ON MMM. DD, YY FOR $XXXX.XX.
09	2	DT	19	ADVISE IF THE SERVICES ON MMM. DD, YY WERE UNDER THE PHYSICIANS'S DIRECT SUPERVISION.
0A	1,2, 3	DR	DC	INDICATE THE FULL NAME AND ADDRESS OF THE SPECIFIC DOCTOR PROVIDING "TYPE OF SERVICE" ON MMM. DD, YY FOR $XXXX.XX.
0B	2,4	DT	DD	ADVISE THE NAME AND ADDRESS OF THE REFERRING PHYSICIAN FOR SERVICES RENDERED ON MMM. DD, YY BY "PROVIDER OF SERVICE."

QUES	INFO	FIELD	DISA	MESSAGE TEXT
0C	1,2, 3,4	LO	DE	INDICATE THE LOCATION WHERE "TYPE OF SERVICE" RENDERED ON MMM. DD, YY FOR $XXXX.XX BY "PROVIDER OF SERVICE". IF IN HOSPITAL, WAS PATIENT AN INPATIENT OR OUT-PATIENT?
0D	2,3	LO	DE	INDICATE THE FULL NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PERFORMED ON MMM. DD, YY FOR $XXXX.XX.
0E	2,3	TS	DF	ADVISE IF THE FEE FOR SERVICES ON MMM. DD, YY FOR $XXXX.XX IS FOR THE PROFESSIONAL, TECHNICAL OR TOTAL COMPONENT.
0F	2	DR	DC	VERIFY WHO IS BILLING FOR THE SERVICES ON MMM. DD, YY FOR $XXXX.XX.
10	0	DT	24	ADVISE THE ADMISSION AND DISCHARGE DATE FROM THE NURSING HOME.
11	0	DT	24	ADVISE IF THE BENEFICIARY IS A PATIENT AT THE NURSING HOME OR IF THE NURSING HOME IS HIS/HER RESIDENCE.
12	1,2, 3	PR	DG	DETAILED DESCRIPTION OR FIVE DIGIT BLUE SHIELD CODE FOR "TYPE OF SERVICE" ON MMM. DD, YY FOR $XXXX.XX.
13	1,3, 4	SD	DH	INDICATE THE DATE OF "TYPE OF SERVICE" SUPPLIED FOR CHARGES TOTALING $XXXX.XX BY "PROVIDER OF SERVICE".
14	1,3	SD	DI	INDICATE EXACT DATE AND CHARGE FOR "TYPE OF SERVICE" ON MMM. DD, YY.
15	1,2, 4	SC	DI	VERIFY TOTAL CHARGES FOR "TYPE OF SERVICE" ON MMM. DD, YY BY PROVIDER OF SERVICE.
16	2,3	DC	DK	INDICATE THE TYPE OF ILLNESS FOR SERVICES RECEIVED BY PATIENT ON MMM. DD, YY FOR $XXXX.XX.
17	1,2, 3	PR	DG	ADVISE THE DIAGNOSIS AND DESCRIPTION OR FIVE DIGIT BLUE SHIELD CODE FOR "TYPE OF SERVICE" ON MMM. DD, YY FOR $XXXX.XX.
18	2,3	PR (TS = 7)	DJ	DESCRIPTION OR FIVE DIGIT BLUE SHIELD CODE FOR SURGICAL PROCEDURE PERFORMED WHEN ANESTHESIA WAS ADMINISTERED ON MMM. DD, YY FOR $XXXX.XX.
19	2,3	UT	DL	NEED DOCTOR'S STATEMENT INDICATING TIME OF ANESTHESIA ADMINISTERED ON MMM. DD, YY FOR $XXXX.XX.
1A	2,4	PR	DI	INDICATE THE SERVICES PERFORMED OR THE FIVE DIGIT BLUE SHIELD CODE AND THE AMOUNT CHARGED FOR EACH SERVICE ON MMM. DD, YY BY "PROVIDER OF SERVICE".
1C	2	PR	DN	ADVISE IF THE LENSES PRESCRIBED ON MMM. DD, YY ARE POST-OPERATIVE CATARACT LENSES.
1D	0	PR	DN	ADVISE IF CATARACT SURGERY WAS PERFORMED ON: RIGHT EYE, LEFT EYE, BOTH EYES, OR NO SURGERY.
1E	0	PR	DN	ADVISE IF CONTACT LENS IS: SOFT LENS (ONE OR TWO LENS) HARD LENS (ONE OR TWO LENS)
1F	0	PR	DN	ADVISE IF YOUR FEE REPRESENTS TEMPORARY OR PERMANENT

QUES	INFO	FIELD	DISA	MESSAGE TEXT
	(CON'T)			GLASSES. INCLUDE IF LENS IS: CATARACT LENS (ONE OR TWO,) BALANCE LENS, PRESS ON LENS, OR SUNGLASSES.
20	0	PR	DN	ARE FRAMES INCLUDED IN YOUR FEE?
21	2	DT	DN	ADVISE THE REASON FOR ORDERING MORE THAN ONE PAIR OF CATARACT GLASSES ON MMM. DD, YY.
22	0	DT	DR	NEED AUTHORIZATION FOR POST OPERATIVE CATARACT GLASSES OR CONTACT LENS FROM AN M.D. OR OPTHALMOLOGIST.
23	0	DT	DG	ADVISE THE NAME OF THE MANUFACTURER OF THE SOFT CONTACT LENS.
24	2	DT	DG	ADVISE IF A REFRACTION WAS INCLUDED IN THE EYE EXAM PERFORMED ON MMM. DD, YY.
25	2,3	DT	DG	VERIFY IF VISUAL FIELDS ON MMM. DD, YY FOR $XXXX.XX WERE MANUAL OR INSTRUMENTAL.
26	2	PR	DG	WAS THE EAR EXAM PERFORMED ON MMM. DD. YY FOR THE PURPOSE OF FITTING A HEARING AID?
27	2,3	PR	DO	INDICATE THE SIZE AND LOCATION OR FIVE DIGIT BLUE SHIELD CODE FOR THE LESIONS OR LACERATION TREATED ON MMM. DD, YY FOR $XXXX.XX.
28	2,3	PR	DO	ADVISE IF THE LESION TREATED ON MMM. DD, YY FOR $XXXX.XX WAS BENIGN OR MALIGNANT. IF MALIGNANT, PLEASE FURNISH A COPY OF THE PATHOLOGY REPORT.
29	0	PR	DO	ADVISE IF PACEMAKER INSERTED WAS TEMPORARY OR PERMANENT.
73	0	DT	DQ	ADVISE DATE OF PACEMAKER IMPLANT.
2A	2	PR	DO	INDICATE EXACT FRACTURE SITE AND TYPE OR FIVE DIGIT BLUE SHIELD CODE FOR REDUCTION PERFORMED ON MMM. DD, YY.
2B	2	PR	DO	ADVISE TYPE, SIZE AND LOCATION OR FIVE DIGIT BLUE SHIELD CODE FOR SKIN GRAFT PERFORMED ON MMM. DD, YY.
2C	2,3	PR	DM	ADVISE THE EXACT LOCATION (VESSEL) OR FIVE DIGIT BLUE SHIELD CODE FOR THE ARTERIOGRAPHY OR ANGIOGRAPHY WHICH WAS PERFORMED ON MMM. DD, YY FOR $XXXX.XX.
2D	2	PR	DM	INDICATE THE NAME OR FIVE DIGIT BLUE SHIELD CODE AND CHARGE OF EACH LAB TEST INCLUDED IN THE LAB SERVICES ON MMM. DD, YY. THIS MUST BE SUBMITTED WITH EACH CLAIM.
2E	2,3	PR	DP	INDICATE THE NAME OF THE MEDICATION AND DOSAGE INJECTED (IM/ IA/IV) ON MMM. DD, YY FOR $XXXX.XX.
2F	2	DT	DC	WHO PREPARED AND/OR ADMINISTERED THE ALLERGY SERUM FOR TREATMENT ON MMM. DD, YY?
30	2	PR	DP	ADVISE IF THE ALLERGY INJECTION ON MMM. DD, YY WAS ALLPYRAL, AQUEOUS, OR EMULSION.

QUES	INFO	FIELD	DISA	MESSAGE TEXT
31	0	PR	DN	ADVISE THE TYPE OF FIVE DIGIT BLUE SHIELD CODE FOR THE BREAST PROSTHESIS (E.G., UNILATERAL/BILATERAL, INTERNAL/EXTERNAL, FOAM/SILICONE)
32	2,3	DT	DQ	PROVIDE PHOTOGRAPHS FOR THE COSMETIC SURGERY PERFORMED ON MMM. DD, YY. FOR $XXXX.XX.
33	2,3	NT	DS	ADVISE THE EXACT HOURS OF INTENSIVE CARE ON MMM. DD, YY FOR $XXXX.XX.
34	2,3	NT	DS	INDICATE THE NUMBER OF HOURS THAT THE AVIONICS SERVICES WERE RENDERED ON MMM. DD, YY FOR $XXXX.XX.
35	2,3	PR	DQ	SEND A COPY OF THE OPERATIVE REPORT OF THE SURGICAL PROCEDURE RENDERED ON MMM. DD, YY FOR $XXXX.XX.
36	2	DT	DQ	SEND A COPY OF PATHOLOGY REPORT FOR SERVICE ON MMM. DD, YY.
37	2,4	DT	DQ	SEND A COPY OF DOCTORS' ORDERS FOR SERVICE ON MMM. DD, YY BY "PROVIDER OF SERVICE".
38	2,4	DT	DQ	SEND A COPY OF NURSES' NOTES FOR SERVICE ON MMM. DD, YY BY "PROVIDER OF SERVICE".
39	2,4	DT	DQ	SEND A COPY OF PROGRESS NOTES FOR SERVICE ON MMM. DD, YY BY "PROVIDER OF SERVICE."
3A	2,4	DT	DQ	SEND A COPY OF DISCHARGE SUMMARY FOR SERVICE ON MMM. DD, YY BY "PROVIDER OF SERVICE".
3B	2	DT	DQ	PROVIDE A COPY OF THE INVOICE FOR THE PROSTHETIC HARDWARE USED ON MMM. DD, YY.
3C	0	DT	DQ	ADVISE IF YOU HAVE A WRITTEN PLAN OF TREATMENT ON FILE IN YOUR OFFICE OR WITH THE PHYSICIAN.
3D	0	DT	DG	ADVISE THE NAME OF THE MANUFACTURER OF THE CEA KIT.
3E	2	PR (TS = 9)	DT	INDICATE THE TOTAL MILES TRAVELED ON MMM. DD. YY.
3F	2	DT	DU	NEED DOCTOR'S STATEMENT INDICATING TYPE OF ILLNESS/INJURY REQUIRING AMBULANCE SERVICE ON MMM. DD, YY. WAS PATIENT BED CONFINED?
40	2	DT	DU	INDICATE REASON FOR TRANSFERRING PATIENT FROM ONE HOSPITAL TO ANOTHER ON MMM. DD, YY. IF FOR FACILITIES, PLEASE ADVISE TYPE.
41	2	DT	DU	INDICATE REASON PATIENT DID NOT GO TO A FACILITY CLOSER TO HIS RESIDENCE ON MMM. DD, YY.
42	0	AC	DQ	ADVISE FEE TO NEAREST FACILITY.
43	2	DT	DE	INDICATE THE ORIGIN AND DESTINATION FOR THE AMBULANCE TRIP ON MMM. DD, YY. PLEASE INCLUDE THE NAMES OF THE INSTITUTIONS.
44	2	DC/DT	DU	INDICATE THE REASON FOR ROUND TRIP AMBULANCE SERVICE ON MMM. DD, YY.

QUES	INFO	FIELD	DISA	MESSAGE TEXT
45	2	DT	DU	ADVISE IF PATIENT WAS TRANSPORTED TO A HOSPITAL, NURSING HOME OR RESIDENCE IN ANOTHER STATE UPON DISCHARGE ON MMM. DD, YY.
46	2	DT	DU	ADVISE IF PATIENT WAS DISCHARGED FROM AN OUT OF STATE HOSPITAL, NURSING HOME OR COMING FROM HIS OR HER RESIDENCE ON MMM. DD, YY. WAS AN AMBULANCE USED TO REACH THE AIRPORT?
47	0	DC/DT	DU	ADVISE NECESSITY OF TRIP TO DOCTOR'S OFFICE BEFORE GOING TO HOSPITAL
48	2,3	DT	DV	NEED DOCTOR'S STATEMENT OF THE MONTHS OF MEDICAL NECESSITY FOR EQUIPMENT PURCHASED ON MMM. DD, YY FOR $XXXX.XX.
49	0	DT	DV	NEED A PHYSICIAN'S STATEMENT INCLUDING PERIOD OF AUTHORIZATION AND MEDICAL NECESSITY FOR FURTHER USE OF DURABLE MEDICAL EQUIPMENT.
4A	2	DT	DD	NAME AND ADDRESS OF AUTHORIZING PHYSICIAN FOR MEDICAL EQUIPMENT OBTAINED ON MMM. DD. YY.
4B	0	DC/DT	DK	ADVISE IF THE PATIENT IS BED____ OR ROOM ____ CONFINED.
4C	2	DC/DT	DK	INDICATE THE TYPE OF ILLNESS WHICH REQUIRES THE PATIENT TO USE MEDICAL EQUIPMENT, WHICH WAS RENTED/PURCHASED ON MMM. DD, YY._____
4D	0	DT	DV	ADVISE THE LITERS OF OXYGEN PRESCRIBED ____ NUMBER OF HOURS ____ PER NUMBER OF DAYS ____ AND/OR THE TYPE OF EQUIPMENT NEEDED WITH THE OXYGEN_____
4E	0	DT	DV	ADVISE IF THE USE OF THE ALTERNATING PRESSURE PAD UNDER THE PHYSICIAN'S SUPERVISION _____
4F	0	DT	DK	ADVISE IF THE PATIENT IS HIGHLY SUSCEPTIBLE TO DECUBITUS ULCERS.
50	2	LO	DE	ADVISE IF THE EQUIPMENT RENTED/PURCHASED ON MMM. DD, YY USED IN PATIENT'S HOME. IDENTIFY LOCATION IF OTHER _____ _____
51	0	DT	DK	ADVISE IF THE PATIENT IS CAPABLE OF EFFECTING ADJUSTMENTS ON THE ELECTRIC BED BY OPERATING THE CONTROLS HIM/HERSELF.
52	2	PR	DW	ADVISE EXACT TYPE OF INHALATION THERAPY AND/OR IPPB EQUIPMENT RENTED OR PURCHASED ON MMM. DD, YY. SPECIFY THE BRAND NAME AND MODEL NUMBER.
53	2	DT	DG	ADVISE THE NAME OF THE MEDICATION USED IN IPPB THERAPY.
54	2	DT	DW	VERIFY IF THE EQUIPMENT BEING REPAIRED IS BEING RENTED OR DOES THE PATIENT OWN THE EQUIPMENT.
55	0	DC/DT	DK	ADVISE IF PATIENT IS AMBULATORY.
56	0	DT	DV	ADVISE IF THE PATIENT IS ON A THERAPEUTIC PROGRAM IN WHICH A PORTABLE OXYGEN SYSTEM WILL SERVE THE PATIENT'S NEEDS.

QUES	INFO	FIELD	DISA	MESSAGE TEXT
57	0	DT	DV	ADVISE IF THE PORTABLE SYSTEM IS USED IN CONJUCTION WITH A STATIONARY UNIT. IF SO, ADVISE THE NECESSITY OF BOTH.
58	0	DT	DW	ADVISE IF THIS OXYGEN UNIT IS PRESET OR REGULATED, THE MAXIMUM FLOW RATE OF OXYGEN AND THE WEIGHT OF THE UNIT.
59	2,3	PR	DN	PROVIDE A DETAILED DESCRIPTION (OR THE FIVE DIGIT BLUE SHIELD CODE) FOR THE BRACE AND/OR PROSTHETIC DEVICE.
5A	0	SD	DX	ADVISE THE EXACT DATE OF EQUIPMENT RENTAL.
5B	2	PR	DW	ADVISE THE EXACT TYPE OR FIVE DIGIT BLUE SHIELD CODE FOR EQUIPMENT BEING RENTED OR PURCHASED ON MMM. DD, YY.
5C	0	DT	DQ	ADVISE THE EXACT DATE OF DEATH.
5D CHAIN TO	0	DT	31	AS THIS BENEFICIARY IS DECEASED, IT IS NECESSARY TO REQUEST THAT YOU VERIFY IF THE BILLS HAVE BEEN PAID, AND, IF SO, BY WHOM.
5E CHAIN TO	0	DT	31	FILL IN HERE TO COMPLETE: PAID _____ OR UNPAID _____: IF PAID, BY WHOM: NAME _____ ADDRESS _____
5F CHAIN TO	0	DT	31	IF THE BILLS ARE STILL UNPAID, PAYMENT CAN BE MADE DIRECTLY TO YOU IF YOU WISH TO ACCEPT ASSIGNMENT ON THE UNPAID PORTION.
60 CHAIN TO	0	DT	31	FILL IN THE INFORMATION HERE: UNPAID _____ I WISH TO ACCEPT ASSIGNMENT: UNPAID _____ I DO NOT WISH TO ACCEPT ASSIGNMENT.
61	0	DT	31	SIGN IN THIS SPACE TO VERIFY THE ABOVE INFORMATION _____ _____
62 CHAIN TO	4	DT	31	OUR RECORDS INDICATE THAT THE BILLS ON THE CLAIM FOR THE ABOVE DECEASED BENEFICIARY ARE NOT PAID. ASSIGNMENT WAS NOT DESIGNATED BY "PROVIDER OF SERVICE".
63 CHAIN TO	0	DT	31	PROOF OF PAYMENT (A RECEIPTED BILL SHOWING WHO PAID THE BILL, A CANCELLED CHECK, A STATEMENT FROM THE PHYSICIAN/SUPPLIER, OR OTHER PROBATIVE EVIDENCE) MUST BE SUBMITTED TO MEDICARE.
64	4	DT	31	HOWEVER, IF YOU WISH AGAIN TO SEE IF HE WILL ACCEPT ASSIGNMENT, YOU MAY CONTACT "PROVIDER OF SERVICE". ADVISE HIM TO SUBMIT A SIGNED STATEMENT TO THIS EFFECT TO OUR OFFICE.
65	0	DT	DV	OUR RECORDS INDICATE THE BILLS SUBMITTED FOR THE ABOVE DECEASED PATIENT ARE PAID. HOWEVER, TO COMPLETE PROCESSING IT WILL BE NECESSARY FOR YOU TO COMPLETE THE ENCLOSED SSA 1660 FORM AND RETURN IT WITH THIS LETTER.
66	4	DT	DQ	ADVICE THE DATE OF DOCUMENTARY XRAY AND DATE COURSE OF TREATMENT BEGAN FOR CHIROPRACTIC SERVICES BY "PROVIDER OF SERVICE".
67	2	DT	DQ	ARE DOCUMENTARY XRAYS AVAILABLE FOR REVIEW FOR COURSE OF TREATMENT BEGINNING MMM. DD, YY.
68	2	DT	DK	ADVISE THE LOCATION OF COMPLAINT (E.G. LUMBO SACRAL, ETC.)

QUES	INFO	FIELD	DISA	MESSAGE TEXT
CHAIN TO	(CON'T)			AND HOW IT DEVELOPED (E.G. FALL, ETC.) FOR SERVICES BEGINNING MMM. DD, YY.
69	0	DT	DK	ADVISE OBJECTIVE PHYSICAL FINDINGS.
6A	0	DT	DK	ADVISE THE PRESENT DIAGNOSIS, SYMPTOMS, AND/OR PROGNOSIS (ESTIMATED NUMBER OF TREATMENTS NECESSARY OR DATE OF DISCHARGE FROM ACTIVE CARE).
CONSULTANTS				
6B	0	DT	DQ	PROVIDE BRIEF SUMMARY OF PATIENT'S PRESENT CONDITION, PARTCULARYLY IF THE DIAGNOSIS HAS CHANGED, EXPLAIN THE CIRCUMSTANCES.
CHAIN TO				
6C	0	DT	DQ	INDICATE TREATMENT PROGRESS FINDINGS INCLUDING OBJECTIVE CHANGES AND THE NECESSITY OF FURTHER THERAPY OR THE DATE OF DISCHARGES FROM ACTIVE CARE.
60	2	DT	06	WAS YOUR ILLNESS OR INJURY OF MMM. DD, YY CONNECTED WITH YOUR EMPLOYMENT?
CHAIN TO				
6E	0	DT	06	WERE YOU COVERED, AT THE TIMEOF YOUR ILLNESS OR INJURY, UNDER A WORKMAN'S COMPENSATION LAW OR PLAN OF THE UNITED STATES OR ANY STATE?
CHAIN TO				
6F	0	DT	06	HAVE YOU RECEIVED A LUMP SUM SETTLEMENT UNDER A WORKMAN'S COMPENSATION LAW OR PLAN IN THE UNITED STATES OR ANY STATE FOR THIS ILLNESS OR INJURY?
CHAIN TO				
70	0	DT	06	DO YOU INTEND, NOW OR IN THE FUTURE, TO REQUEST PAYMENT UNDER A WORKMAN'S COMPENSATION LAW OR PLAN IN THE UNITED STATES OR ANY STATE.
71	2,3	DT	08	TO WHAT LAND (COUNTRY OR STATE) WERE YOU NEAREST WHEN SERVICES WERE RENDERED ON MMM. DD, YY FOR $XXXX.XX AND/OR WAS THE SHIP WITHIN # MILES OF THE UNITED STATES COAST?
CHAIN TO				
72	0	DT	08	IF THE SHIP WAS LOCATED IN THE GULF OF MEXICO NEAREST FLORIDA, WAS IT WITHIN 9 MILES OF THE FLORIDA SHORE?

ABBREVIATIONS - FIELD INFORMATION MISSING

NM	NAME & ADDRESS FIELD
DR	DOCTOR CODE FIELD
SD	SERVICE DATE FIELD
LO	LOCATION OF SERVICE FIELD
PR	PROCEDURE CODE FIELD
TS	TYPE SERVICE FIELD
UT	UNITS OF TIME FIELD
SC	SUBMITTED CHARGE FIELD
NT	NUMBER OF TREATMENTS FIELD
DT	DOCUMENTATION TAG FIELD
DC	DIAGNOSIS CODE FIELD
AC	ALLOWED CHARGE FIELD
DF	DISALLOW CODE FIELD

24 DISALLOW MESSAGES

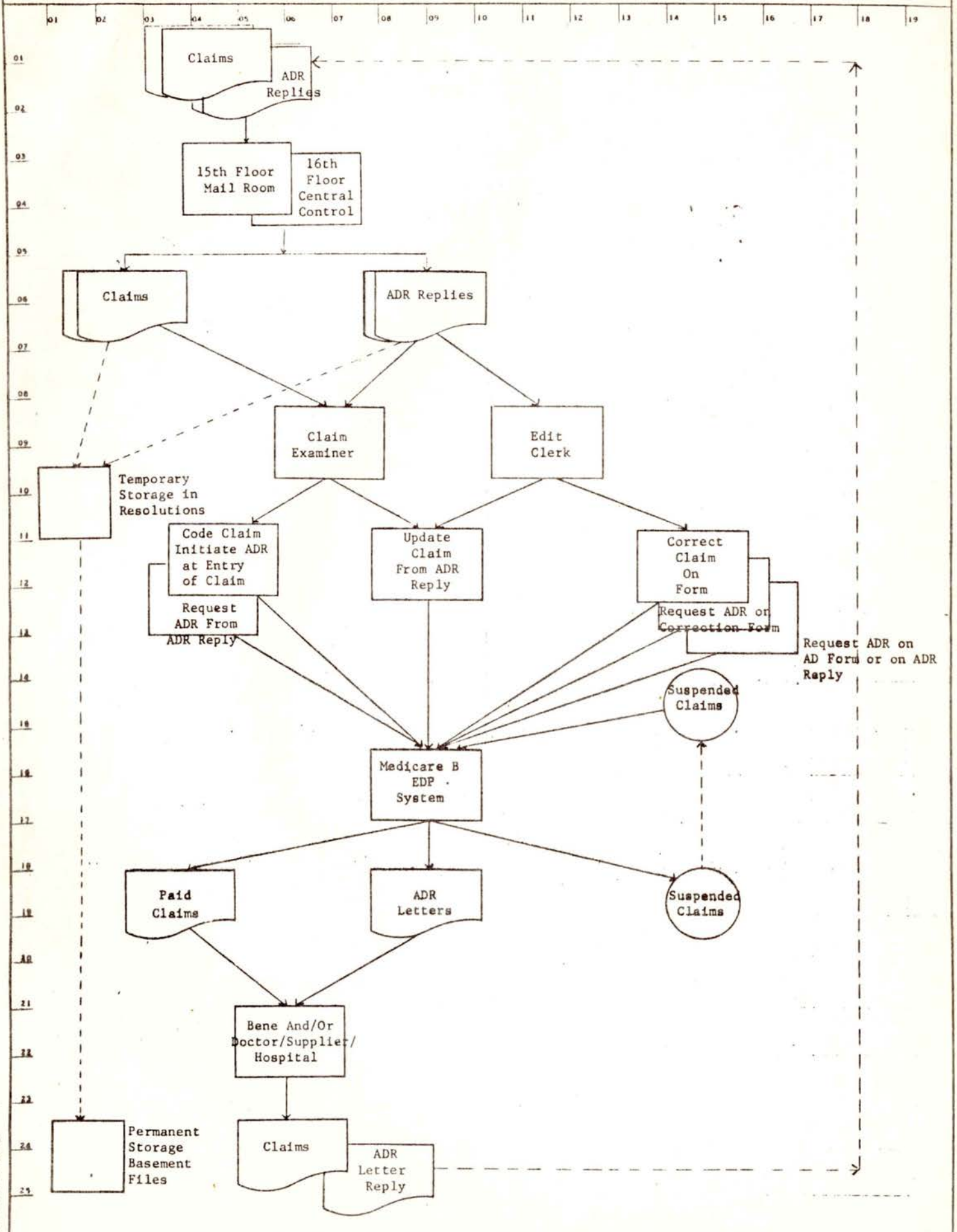
Code	Prints Message on EOMB
DA	CLAIM WITHOUT PATIENT'S RELATIONSHIP TO PROVIDER
DB	CLAIM NOT SIGNED BY PROVIDER OF SERVICE
DC	CHARGES WITHOUT PROVIDER'S NAME AND ADDRESS
DD	CHARGES WITHOUT NAME OF REFERRING PHYSICIAN
DE	CHARGES WITHOUT LOCATION OF SERVICE SHOWN
DF	CHARGES WITHOUT COMPONENT TYPE SHOWN
DG	CHARGES WITHOUT COMPLETE DESCRIPTION OF SERVICE
DH	CHARGES WITHOUT DATES FOR EACH SERVICE
DI	CHARGES NOT ITEMIZED FOR EACH SERVICE
DJ	ANESTHESIA WITHOUT TYPE OF SURGERY
DK	CHARGES WITHOUT DOCTOR'S DIAGNOSIS OF ILLNESS
DL	CHARGES WITHOUT TIME OF ANESTHESIA
DM	CHARGES WITHOUT EXACT TYPE OF LAB OR X-RAY
DN	PROSTHETIC DEVICE WITHOUT COMPLETE DESCRIPTION
DO	SURGERY WITHOUT COMPLETE DESCRIPTION
DP	INJECTION WITHOUT TYPE SHOWN
DQ	SERVICES WITHOUT REQUIRED DOCUMENTATION
DR	CATARACT LENSES WITHOUT AUTHORIZATION
DS	CHARGES WITHOUT LENGTH OF TREATMENT
DT	CHARGES WITHOUT TOTAL MILAGE
DU	AMBULANCE WITHOUT STATEMENT OF NECESSITY
DV	MEDICAL EQUIPMENT WITHOUT AUTHORIZATION
DW	MEDICAL EQUIPMENT WITHOUT COMPLETE DESCRIPTION
DX	EQUIPMENT RENTAL WITHOUT INCLUSIVE DATES
DY	RECEIPTS WITHOUT A LEGAL REPRESENTATIVE PAYEE

Other Routine Disallow Code Used in ADR

Code	Prints Message on EOMB
06	Services covered by workman's Compensation
08	Services outside U.S.
19	Services not under Doctor's Direct Supervision
20	This claim was disallowed because the patients signature was not on the claim form.

Application Additional Development Date 11-3-75 Page 1 of 1

Procedure Form & Work Flow Drawn By Lucy White



Fold to dotted line

REQUEST FOR ADDITIONAL DEVELOPMENT

DATE: _____

CLERK: _____

CONTROL NUMBER	REPORT NUMBER	PROCESS DATE	CLERK	LINE CODE	FIELD CODE	DATA
					AD	
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PROCEDURE CODES SPEED CLAIM PROCESSING

MEDICARE PART 'B'

POST OFFICE BOX 2525 JACKSONVILLE, FLORIDA 32203

ADMINISTERED BY BLUE SHIELD OF FLORIDA, INC.

ACCURATE PAYMENT OF THIS CLAIM DEPENDS UPON YOUR RETURNING THIS FORM

MED-833 B (11/75) A

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FOR OFFICE USE ONLY

01 CONTROL NUMBER	02 REPORT NUMBER	03 PRIOR AUTH. DATE	04 HCFA NUMBER	05 DIS. DATE	06 CLAIM ID NUMBER

09 BENEFICIARY NAME AND ADDRESS 39 C. C. NO.

10 SEX	12 A.R.	13 CLINIC	14 ASG	15 TOT. CHG.	16 PD. BY BENE.	17 DISP. CODE	18 PROV.	19 MSG.	27 YR.

LINE NO.	20 DR. SUPP. NO.	21 DR. SUP.	22 ID. TAG	23 SERVICE FIRST	24 DATE LAST	25 NO. SRT.	26 LOC.	27	28 TYPE SVC.	29 PROC. CODE	30 ALLOWED CHARGE	31 DR. SUPP. CHARGE	32 DIS. ALL.	33 UNIT	34	35 DIAG. CODE	36 FLD. CODE	37 DATA

USE THIS SPACE FOR ADDITIONAL INFORMATION

MED-8338 (11/75) B

ACCURATE PAYMENT OF THIS CLAIM DEPENDS UPON YOUR RETURNING THIS FORM

Example only

ADR

○ ASSIGNED ○ UNASSIGNED

SVC YR	DISPOSITION	MSG	CKD	CLINIC CODE	PROVIDER	PAID BY BENE	ADR	SPLT	PAGE
A									OF

LN NO	TEL SVC	SERVICE DATES	LOC	GL	TYP SVC	PROC	DM IND	DIAGNOSIS CODE	DOCTOR CHARGE	CHECK DOCTOR CODE	ALLOWED CHARGE	DISA CODE	%	ADR	DC

(CUT - OUT)

TOTAL CHARGE

Form MED. 335 B1 Rev. 10/75

MEDICARE PART B CLAIM CORRECTION FORM

CONTROL NUMBER	REPORT NUMBER	PROCESS DATE	HIB NUMBER	JULIAN DATE	ERROR FREQ	CLAIM CLERK NUMBER	KEYPUNCH OPERATOR	KEYPUNCH VERIFIER	BATCH NUMBER	PAGE
01	02	03	04	05		06	07	08		

BENEFICIARY NAME

STREET ADDRESS

CITY-STATE-ZIP CODE

09

SEX	EMP REL	CLINIC CODE	ASG CODE	TOTAL CHARGES	PAID BY BENEFICIARY	DISP CODE	PROVIDER NUMBER	MSG CODE	YR	ERROR CORRECTION FIELD CODE
10	12	35	14	15	16	17	18	36	17	1 2 3 4 5 6 7 8 / 1 2 3 4 5 6 7 8

DETAIL LINE	DR/SUPPLIER CODE	DR SUFFIX	DOCU TAG	FIRST SERVICE DATE	LAST SERVICE DATE	NO OF TRTS	LOS	GL CDE	TYPE SVC	PROCEDURE CODE	ALLOWED CHARGE	DR/SUPPLIER CHARGE	DISALLOW CODE	CNTY CODE	R/C TAG	DIAGNOSIS CODE
	19	20	41	21	22	23	24	40	25	26	27	28	29	30	31	38

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